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THE JOURNAL OF SCHOOL HEALTH

Devoted to the interests and advancement of school health service and instruction.
Your participation by membership is solicited.

Vol. XXII APRIL, 1952 No. 4

WHAT IS THE TRAINING OF HEALTH TEACHERS IN OREGON HIGH SCHOOLS?

JENNELLE MOORHEAD, M.S.
University of Oregon and General Extension Division

The material I am presenting today is from a study I made as part of the research program of the School of Health and Physical Education, University of Oregon. In my professional position, I direct Health Education Workshops for teachers through the General Extension Division of the Oregon State System of Higher Education. I am, therefore, intensely interested in the preparation of teachers to teach health education.

In organizing an effective in-service training program for teachers, it is important to know in what areas they are well-trained and where they have little training. To obtain the necessary information that would show their training, I secured the transcripts which covered the training of the health teachers in Oregon junior and senior schools and examined these transcripts very carefully. I might state that it was not easy to secure the names of these teachers. The names when secured were verified by school administrations to make sure that only the proper names were included. The school administrators in 92 per cent of the junior high schools and 83 per cent of the high schools responded, while 8 per cent of the junior high schools and 17 per cent of the high school administrators did not reply. Out of the high school administrators responding, only 9 stated that their high schools did not provide health instruction in the school year 1946-47. This gave me the names of 367 teachers from 227 schools with an approximate enrollment of 48,000 for my study and left the possibility of error in this study rather small since there are only 37 junior high schools and 233 high schools in Oregon. This gave me returns from 227 out of 260 schools.

The various teacher-training institutions where these teachers had had their training were most cooperative in providing the needed transcripts. The point should be made that these transcripts were secured directly from the registrars of the teacher-training institutions, not from the teachers. Some 67 institutions

provided data. First inspection of the data indicated that 88 per cent of the health teachers received their training in Oregon while 22 per cent were trained outside of the state. So the improvement of the training of Oregon health teachers is an Oregon educational problem. The transcripts also revealed that over half of the high school teachers, 58 per cent, held B. S. degrees, 34 per cent held B. A. degrees and 8 per cent had not completed degree work although a bachelor's degree is considered to be a requirement for high school teaching. It should be mentioned that 33 per cent of the junior high health teachers had not completed their bachelor's degree work. This can be attributed to the fact that many junior high teachers had a background of elementary education training and may teach with two or three years of college preparation.

There was no evidence that the teachers without degrees were teaching health because of special qualification. Therefore, such a large percentage without degrees presents another aspect of the problem. The study did not include an analysis of master's degree work. However, it was observed that only a small number of teachers had master's degrees.

The Oregon institutions in which these teachers took their training is of considerable interest particularly to Oregon educators. Of the junior high teachers 29 per cent were trained at the two major Oregon institutions, 44 per cent were trained at the three state elementary teacher-training institutions and 12 per cent were trained by private institutions. At the high school level 41 per cent were trained at the two major institutions, only 5 per cent at the elementary teacher-training institutions and the private institutions trained 31 per cent. Because these teachers come from so many institutions, great diversity in training is indicated particularly since health education training is not standardized. Also it is well known that there is considerable difference of opinion concerning how health education is to be undertaken. For this reason, teacher preparation at the different institutions varies widely.

The training of these teachers should be reviewed in light of national recommendations. Committees from the American Medical Association, National Education Association, American Public Health Association and the American Association of School Administrators have generally recommended that teachers with majors in biology, general science, social science, home economics and physical education should teach health education. The transcripts of these Oregon teachers revealed that their training did not follow

the national recommendations except in the case of the physical education majors. At the junior-high level, 24 per cent were physical education majors while 19 per cent had majored in education and 12 per cent in elementary education. Almost half, 45 per cent, had a large variety of majors. Three teachers were history majors! There were just as many teachers with English majors as with biological science majors, two in each case, even though biological science is one of the major fields of preparation recommended by National Committees and in no instance has an English major been recommended as preparation for teaching health. The national recommendations also suggest majors in home economics, science and social science. Each field was represented by only one teacher while the remaining teachers in this group had majored in business administration, commerce, music and psychology. There was one teacher who had a two year health education major from an elementary teacher-training institution. Thus with almost half of the teachers having such widely varied college preparation, a very serious problem is presented.

The major training of high school health teachers indicated that again the findings did not follow national recommendations. When we break down the training of the high school teachers by major fields of preparation, we find that the largest percentage, 28 per cent, were physical education majors as recommended, and 16 per cent were education majors. There were just as many teachers with history majors, 6 per cent, which is not a recommended field of preparation, as with home economics major which is recommended. There were also more teachers with English majors, 5 per cent, than teachers with biology, 3 per cent, which is a recommended field. The remaining 35 per cent had 25 different majors. This breakdown indicated there is little correlation between the teachers' preparation and the teaching of health. The following list of majors indicate this clearly. They are as follows: agriculture, arts and languages, botany, business administration, engineering, chemistry, commerce, drama, economics elementary education, foreign languages, forestry, general science, industrial education, Latin, mathematics, music, philosophy, political science, psychology, pyschology and education, secretarial science, social studies, speech and vocational education..

It would appear that many of these teachers were teaching health not because their training prepared them to teach health but because their assignment to health teaching by administrators made for convenient scheduling.

In order to determine how well a teacher is prepared to teach health in any state, an analysis of the health facts to be taught in that state as required by the course of study is necessary. In industry this would be called "job analysis." The procedure used in this study could be used in any state to measure the preparation of teachers. In making the job analysis of Oregon's health education teachers, the Oregon state course of study in health was meticulously analyzed in order to set up a standard whereby the training could be evaluated. The Oregon state course of study has nine major units which are: personal hygiene, community health and sanitation, communicable diseases, nutrition, mental health, first aid and safety education, choice and use of health services and health products, physiology of exercise, and structure and functions of the human body. Each separate health topic in these units was numbered. As an example, the unit on Physiology of Exercise had 25 separate health topics, Personal Hygiene 22 separate health topics, First Aid and Safety 21 health topics, etc. By this procedure it was found that the Oregon high school health teacher is expected to teach in the nine different units 534 separate health topics.

The second step in preparing a standard to measure the training was to prepare a scoring sheet listing the names of the various teacher-training courses that had been recommended by national health and education committees. The health topics in the state course of study were then scored in the various courses to determine which courses included the most health topics and therefore made the most direct contribution to the training of an Oregon health teacher.

The placement of health topics was on the basis of whether or not it was included in a standard textbook recommended by experts in various teacher-training institutions. As an example the topic "cells, tissues, organs and body systems" which occurs in one of the units of the State Course of Study Structure and Function of the Human Body was assumed to be best covered in biology, physiology and anatomy courses.

Since the findings in the junior-high school section of this study are similar to those of the high school section of the study, the statistics in the rest of this paper will therefore deal only with the data from the high schools.

By the above procedure of scoring the health topics under courses taken for college credit, it was found that 16 courses made the most direct contribution in training a teacher to teach the nine major health units included in the official course of study. These

16 basic courses are listed in rank order of their contribution. The number of health topics in the State Course of Study scored in each course is indicated and the percenatge of teachers taking these courses is given:

Courses in rank order	No. of Health topics scored from State course of study	Percentage of teachers taking courses
1. Personal hygiene	85	20
2. Mental hygiene	52	22
3. Public health	47	2
4. Physiology of Exercise	35	15
5. Psychology of personality	33	2
6. Adolescent psychology	31	27
7. Psychology of Adjustment	30	2
8. Nutrition	29	21
9. Community hygiene	25	18
10. Marriage and family relations	22	18
11. Physiology	20	37
12. Social hygiene	19	2
13. First aid	18	34
14. Communicable disease	17	3
15. Anatomy	14	31
16. Basic Zoology	12	51
17. Health introduction methods & material		29

From the viewpoint of the direct contribution made by these courses to the training of these health teachers with 25 different majors it should be pointed out that (1) 80 per cent had not taken a professional course in personal hygiene—the first ranking course. (2) 78 per cent had not taken an undergraduate course in mental health—the second ranking course. (3) that 98 per cent had not taken the third ranking course—public health. It should further be noted that the courses the highest percentage of teachers had taken were mainly those that ranked low in making the greatest contributions to preparation for teaching Oregon's health instruction course.

The training of Oregon's health teachers can be viewed from another viewpoint. What courses had most of the teachers taken and which units in the state course of study were they therefore best prepared to teach? It would appear that more teachers were prepared to teach the units—Structure and Function of the Human Body and First Aid than any of the other units, since 51 per cent had taken basic zoology, 37 per cent had taken physiology, 31 per cent had taken anatomy and 34 per cent had taken first aid. From the standpoint of which units are these teachers least prepared to teach on basis of their undergraduate training, it is quickly noted

these are Communicable Disease, Physiology of Exercise, Community Hygiene and Nutrition. With respect to training in Health Education Methods and Materials, less than one out of three teachers has taken such a course which indicates their training is weak in techniques and procedure as well as in content preparation.

Since the percentage of teachers with physical education majors is the largest group and one of the majors nationally recommended, it is important to see if these teachers are better prepared than the health teachers as a whole. It was found that the percentage of health teachers with physical education majors taking 9 of the 16 courses basic to the state course of study in health exceeded the group as a whole and also exceeded the percentages for any other major. With respect to the course in health instruction methods and materials, 60 per cent or 3 out of each 5 teachers had taken such a course as compared to 29 per cent for all the teachers. These teachers were also much better prepared to teach the units Structure and Function of the Human Body, First Aid and Community Hygiene and Physiology of Exercise since 88 per cent had taken basic Zoology, 70 per cent had taken Anatomy, 67 per cent had taken Physiology, 58 per cent had taken First Aid and 42 per cent had taken both Community Hygiene and Physiology of Exercise. It should also be noted that a higher percentage of Physical Education majors had taken the first ranking course, Personal Hygiene, than any other major.

In order quickly to compare the training of the various majors, the following table is presented. Several points should be made in connection with it. First, the Physical Education majors are the only majors who as a whole have taken all 16 courses. No one in the education major group had taken courses in Public Health or Psychology of Adjustment. The history majors had five courses completely missing. The home economics majors had three missing courses, however, all of them had taken Nutrition. The English majors were very poorly prepared since out of the first six ranking courses five had not been taken by any one. Two other courses were missing out of the 16 and no one had taken a course in Health Instruction Methods and Materials.

Special attention should be given to the findings with respect to the Biology majors since it is often recommended they should teach health even though the percentage teaching in Oregon is very small. Out of the first 9 ranking courses, *six had not been taken by any one.* It should be pointed out that the courses that should make the practical health application of biological knowledge are

not included in their training. These are Public Health, Communicable Disease, Community Hygiene and Nutrition. This group, however, had taken the largest percentage of Physiology (79) and all had taken basic Zoology.

Percentage of Teachers Taking Courses Basic to the State Course of Study arranged by majors.

Courses in Rank Order	PE	Ed.	History	Home Ec.	English	Biology
1. Personal hygiene	36	18	11	5	13	22
2. Mental hygiene	28	27	5	21	—	22
3. Public health	5	—	5	5	—	—
4. Physiology of Exercise	42	10	5	5	—	—
5. Psychology of Personality	—	2	4	—	—	—
6. Adolescent Psychology	26	41	26	11	13	22
7. Psychology of Adjustment	5	—	—	5	7	—
8. Nutrition	36	10	5	100	7	—
9. Community hygiene	42	16	5	—	7	—
10. Marriage & Family Relations	15	22	5	58	7	22
11. Psysiology	67	29	16	63	—	79
12. Social hygiene	1	2	—	5	7	—
13. First aid	58	37	—	26	20	33
14. Communicable Diseases	9	2	—	—	—	—
15. Anatomy	70	22	16	11	7	44
16. Basic zoology	88	63	63	47	40	100
17. Health Inst. Methods & Materials	60	18	21	5	—	22

When we take an overall view of the preparation of these teachers it is very spotty with no apparent ordered program of study or curriculum leading to teaching in health. The only exception would be the physical education majors who come somewhat near meeting the standards set. The others had taken the needed courses by chance without selection as to being basic to health teaching. Further evidence was available that these teachers did not intend to teach health and therefore had not made their selection of courses on the basis of preparing them to teach health. These findings would also indicate that the ordinary preparation of a teacher with respect to health is at a low level.

Time will not permit going into the portion of this study which deals with the actual number of hours taken by these Oregon teachers in each course. In closing it can only be mentioned that minimum standards stated in term hours were set up and the training of these teachers evaluated from this viewpoint. Those interested in this aspect and other details of the study can secure the original study from the Oregon Collection at the University of Oregon library.

WORKSHOP TECHNIQUE'S UNIQUE CONTRIBUTION TO HEALTH EDUCATION

ROBERT HASTINGS PATTY
Indiana University

A workshop is defined in Webster's Collegiate Dictionary as "a shop where any manufacture or handiwork is carried on." How does a health workshop fit this definition? The sponsors of a health workshop which attempts to meet the requisites of the definition are striving to display their handiwork in the form of health knowledge, leadership, and organizational ability. They endeavor to mold the participants so that they will be able to perform the same handiwork in turn, for once the handiwork has been mastered, the participants can return to their respective communities and put these skills into practice.

In order to get a broader picture of the health workshop, it would be well to discuss what has been done in the past what can be done in the future.

What Has Been Done

During the month of August, 1951, the Eighth Annual School and Community Health Workshop was sponsored by the Indiana State Board of Health, the Indiana Department of Public Instruction, and the School of Health, Physical Education, and Recreation of Indiana University. These workshops were inaugurated in 1944 and have been conducted annually since then. Each of the workshops was held for 15 consecutive days on the Bloomington Campus of Indiana University.

Basic Principles—Before going further in this discussion, it might be well to outline some of the basic principles which govern this workshop.

1. The membership of the workshop is open to all individuals or representatives of groups who are interested in health services and/or health education.

2. Selected health consultants are on hand to provide expert advice to the participants.

3. The group work is conducted according to the principles of the group process. It must be democratic in order to secure the free thinking that is necessary.

4. The size of the working groups is limited to approximately 15 participants. This does not limit the number of participants because there is no limit on the number of working groups.

5. All of the participants and consultants are encouraged to be participators and not "wall flowers."

6. The consultant staff is supplemented by a nationally known health educator. This person acts as a consultant and calls upon his past experiences to answer questions of the working groups and to inform the people how other states are attacking their health problems.

7. The general program is varied to include addresses, panel discussions, demonstrations, field trips, etc. Ordinarily, the specialist responsible for that area of health being discussed, presents the program. The general program includes lay persons as well as professional health personnel.

8. The Steering Committee of the workshop is responsible for the over-all direction. In general, it selects the areas for the problems, outlines the program, and appoints the participants to the most suitable working groups in view of the participant's choice or his experience.

Organization—The organization of the workshop is relatively simple. First, there are two co-directors, one representing the State Board of Health and the other representing the University. The major responsibility of the co-directors is to carry out the decisions of the Steering Committee in administering the workshop, doing such things as contacting the participants and arrangng for the facilities and equipment. Second, there is a Steering Committee. This committee is composed of 15 representatives of the co-operating agencies. The major responsibility of this committee is to organze the workshop. Its specific duties have been outlined above.

Within each working group there are six people with specific responsibilities. The most important person, as far as the working group is concerned, is the group leader. He acts as a mediator and keeps the group working. To aid him with his responsibilities, the group elects a co-leader. There are two recorders who record the results of the group. They act in the capacity of secretaries.

The recreation representative is a member of a committee which plans a recreation program for the participants. Finally, the reviewer is a member of a committee which meets at the end of the workshop to criticize the workshop experience and make suggestions for future workshops.

There remains but one person who is very important, the co-ordinator. He expedites the program. He is the liaison person whose responsibility it is to see that every phase of the workshop runs smoothly.

Program—The total workshop program is divided into two major phases, the group work and the general sessions. The group work sessions, which occupy about one-half of the participants' time, are used to discover the health problems, discuss them, and outline a method or methods of solving the problems. The problems used are in the following areas: (1) organization and administration of a program, (2) facilities needed for a program, (3) best uses of community resources, (4) problems related to services, (5) problems related to instruction, (6) environmental sanitation and communicable diseases, and (7) problems of the aging.

To assist the working groups during the working sessions, nineteen consultants, plus the visiting consultant, are available to answer any specific question concerned with their specialty. It should be understood that these consultants are professional health people who believe the workshop to be sufficiently worth while to devote their time and effort to it. They represent many different phases of the field of public health, school health, sanitation, nutrition, medicine, dentistry, nursing, and so on, while the visiting consultant is a well-known health educator from outside the state of Indiana.

The general sessions occupy about half of the workshop time. They take the form of addresses by health and lay persons, demonstrations, field trips, panel discussions, and progress reports. Some of the topics used for these programs are: Full-time Health Department, Effective Use of Publicity Media, and Demonstrations in Family Life Education. The field trips are tours of the Indiana University Medical Center and other health and welfare agencies in Indiana.

One of the important phases of this workshop is the recreational activities available to the participants. Since the intensive program of general sessions and group work for the participants is scheduled throughout the day, the late afternoons and evenings are often free for recreation. In order to plan this program, one member of each working group with the co-directors and the co-ordinator form the recreation committee. The responsibility of this committee is to plan and execute a program of recreation. The recreation program ordinarily consists of *evening social mixers*, which include circle and square dances and group sings, softball games with other campus workshops, and a stunt night.

Other after-session activities include the showing of the latest moving pictures in the field of health education and displays of the publications and mock-ups of the voluntary and official agencies.

These activities are an additional service to the workshop participants rendered by the consultant staff. The consultants are usually able to answer many personal questions concerning the location of health materials, equipment and supplies.

Participants—There were 183 participants in the School and Community workshop during August 1951. Of these, 103 were full-time participants and 80 part-time participants.

It is interesting to note the number of different professional groups participating and benefiting from the experience. The results of a breakdown were as follows: teachers, 70—elementary 26, secondary 22, and college 22; representatives of voluntary agencies, 31; nurses, 18; representatives of the State Board of Health, 16; college students, 14; public school administrators, 11; physicians and dentists, 10; representatives of other official agencies, 6; and people not covered by the above classifications, 7. Total participants, 183.

Housing—The 1951 workshop was housed in "West Hall," one of the men's residence centers. All of the sessions, with the exception of the field trip and the two Sunday breakfast meetings, were held in lounges and a general session room in this building. Furthermore, most of the workshop participants resided in this building. The only time that it was necessary for the people to leave the building was at meal time. Meals were served, cafeteria style, to the group in a private dining room of the Student Union Building two blocks away.

Finally, the results of the working groups, a list of the personnel of the workshop, a summary of the general sessions, and a copy of the program were mimeographed and bound. These final copies of the results of the workshop were sent, gratis, to all of the workshop participants.

What Can Be Done

It may be difficult to see how a workshop of this type can fit into a local situation. There are several methods that can be employed to achieve similar results. It should be understood that the major benefit of the workshop is not necessarily the increase in fundamental health knowledge; rather it is the value of improving health attitudes through experiencing of democratic group process. Undoubtedly in most communities there are several persons who have the actual factual material at their command so that it would be unnecessary to take so much time in reaching the conclusions of the working groups. But, after taking part in a workshop as a member of a democratic discussion group, one has

a better understanding of the health problems considered.

The use of the workshop technique should not be construed to be the only method of attack in health education. It is, however, an effective method of educating groups in a community.

School Workshop—The workshop technique can be adapted for use in the classroom. It is true that it would have to be modified considerably, but it can be used to provide a meaningful experience for the student.

The organization of such a workshop could be very similar in principle to the one outlined in this paper. Members of the student body could be assigned to make special investigations into the workings of the voluntary and official agencies concerned with community health services and community health education. These students would then act as consultants. The teacher would act in the same capacity as the visiting consultant. Selected students or patrons might preside over general sessions of the class.

Depending upon the size of the class, working groups could be organized with 10 to 12 members to each group. The group would then appoint a member of their body as the leader. These appointed leaders plus the teacher would then form the Steering Committee. Once the Steering Committee is formed, it could decide which of the community health problems need to be attacked. The leader would then return to the working group and appoint a co-leader, recorders, and a reviewer. Once the organization has reached this point, the group is ready to function. The working groups should be separated into different parts of the classroom, or, if possible, into different conference rooms to achieve the best results. After appropriate periods of time the recorder would then report the findings of the working group to the class.

As said before, this is only one method of attacking the problem of health education. It is believed that good results can be attained if the workshop method is used with a given class only occasionally.

Community Workshop—The workshop technique can also be adapted for use in the community. Problems of community workshops will be found to differ from those met when conducting classroom workshops. It is possible to adjust to these differences and still provide a worthwhile experience.

The major problem will be that of time. When is it possible to get all of the interested individuals together? It is true that a short concentrated period for the workshop will probably bring the best results, but in most communities this is out of the question. There

remain three possibilities: (1) interested people could meet nightly during a two or three week period; (2) interested people might meet during the evenings two or three times a week over a period of six or seven weeks; or, (3) interested people might meet one evening a week for an indefinite period of time.

Who would attend such a workshop? Any person interested in the health of the community would be welcome. Naturally the organizer would invite key health leaders to participate. In many cases, it would be impossible for all of the people to attend all of the meetings, but it should be stressed that the success of the workshop will depend largely upon conscientious attendance.

Who would sponsor such a workshop? Probably the sponsoring agency would be the chief community organization for promoting health. It might be the health council, the department of health, or the public schools. Of coures it may be best if the workshop is sponsored by a combination of these groups.

What should constitute the program of such a workshop? The program would depend upon the health conditions of the community within which the workshop is being conducted. Vital community health problems should be attacked and discussed. Perhaps specific plans would be developed, but in any case much critical thinking would be stimulated. This might lead eventually to solutions of important health problems.

Conclusion

The health workshop technique is a method which merits use in health education. It should not be used as an end, but as a means to an end. With certain adaptations, the workshop technique can be used in the classroom and in the community. The results obtained from the workshop experiences depend upon the efforts that are put into it. If used correctly, it should do much to improve the health program of the community. It provides opportunities for members of school and community health groups to effect the solution of their health problems through participation in democratic group processes.

The unique contribution of the workshop technique to health education is in causing significant and permanent improvements of attitudes toward health and health problems on the part of participants.

* * * * *

LET US NOT DISCARD TUBERCULIN TEST IN TUBERCULOSIS CASE FINDING

Abstracted from paper presented by Abraham E. Jaffin, M.D., President, New Jersey Tuberculosis League, and Chief of Hudson County Chest Clinics, at 44th Annual Meeting of the New Jersey Tuberculosis League, Trenton.

No other country can boast of greater accomplishment and a lower death rate in the battle against tuberculosis than are found in the United States. Many nations with much older civilizations and cultures still have the high death rate that prevailed with us 50 years ago. Admitting that much of our favorable position is due to higher standards of living and other factors, the decline in tuberculosis incidence and mortality would not have been what it is without the cooperative efforts of our predecessors and contemporaries in the fight against this disease.

Today we are a part of an army of more than 100,000 individuals who are, in some way, voluntarily connected with our program. It has been pointed out that we engage the full-time service of more than 1500 professional persons throughout the country. There are about 3000 state and local associations commanding the voluntary services of over 50,000 board members, and at least 50,000 more serve on committees. Yet, with all this effort and accomplishment, tuberculosis is still killer No. 1 on the list of communicable diseases. There is evidence that there are at least half a million cases of active tuberculosis in this country and half of these are unknown in spite of the fact that the death rate for the United States is approximately 30 per 100,000 of the population. In 1948, provisional figures showed that there were 44,000 deaths from tuberculosis in the United States. This disease thus killed at the rate of almost 1000 per week, 125 per day and 1 every 11 minutes.

Major Trends Revealed by Study

A critical study of this decline of the death rate however reveals three major trends:

1. It is still the first cause of death from disease among persons from 15 to 44 years of age.
2. The proportion of tuberculosis deaths is shifting to the older age groups.
3. The decline in the tuberculosis death rate among women has been far more rapid than among men (Tuberculosis Transactions, 1947).

The indications for future actions are clear, for, of the estimated half million cases, only half are known. The unknown quarter of a million must be found before they spread infection to many other thousands. This must be done by continued education and expended case finding directed especially toward certain population groups, older people, high schools, colleges, hospitals, clinics, custodial institutions, and in private practice.

Organized medicine in this State has endorsed health surveys. The State Health Department has made great progress in industrial and other surveys. New Jersey was the first State in the Union to require school surveys by law. It has been pointed out that indiscriminate community surveys do not yield enough cases to make the effort worth while as compared to the results of surveys directed toward special groups. The general incidence of significant findings is rather low, especially in the younger age groups. The findings in the older age groups are more numerous, especially in crowded city areas. The greatest yield is more likely in hospitals, clinics, custodial institutions, and industry. We are getting more older people in community surveys likewise.

Preliminary Tuberculin Screening Reduces Waste Effort, Expense

The incidence of tuberculin reactors and cases of tuberculosis in high school and college students is also much lower than it was 10 years ago when New Jersey instituted school surveys. There is, therefore, a great deal of waste effort and expense in X-raying all students without preliminary tuberculin screening. Unfortunately, there is an erroneous impression growing in some parts of the State that tuberculin testing has been deemed unnecessary. School physicians have been quoted in some counties to the effect that the decision to omit tuberculin tests was based on the advice of tuberculosis authorities. Nothing could be farther from the truth! In reply to a questionnaire recently sent out to the members of the Advisory Committee on Chest Diseases of The Medical Society of New Jersey, it was unanimously agreed that tuberculin screening should not be abandoned.

There is probably no greater authority on the problem of eliminating tuberculosis, especially among children and young people, than Dr. J. A. Myers, Professor of Preventive Medicine in the University of Minnesota. In a recent statement, he wrote: "I also followed the tuberculin testing of pupils of grades 9, 10, 11, and 12 annually, with X-ray inspection of the chests of the tuberculin reactors.

"I have looked upon this as one of the finest programs in the

world and have called attention to it in several articles and in one or two of my books. This fundamental program that has been operating in New Jersey is one that should be adopted by every community, state, and nation.

Surveys Locate Those With Extensive Disease

"Mass X-ray surveys have become popular in some places and they have a definite value. However, such surveys miss far more tuberculosis than they find because the X-ray is a method of finding only gross tuberculous lesions. Such surveys are a good screen to quickly locate persons with extensive disease, but beyond that they are not only worthless, but misleading. I use the word "misleading" advisedly because we have so often seen persons who have clear X-ray films in a mass survey, but within a matter of weeks or months there is evidence of plainly demonstrable pulmonary tuberulcosis, and all too often, positive sputum. Often, these persons have been misled by being told previously that they did not have tuberculosis when the tuberculin test would have detected the presence of tuberculous lesions in the pre-X-ray stage.

"I feel it would be disastrous if the New Jersey groups were to discontinue their present splendid fundamental program and substitute mass X-ray surveys. This would immediately remove your program from the first class and give it a much lower rating. I realize that there has been a great deal of propaganda for mass X-ray surveys which to a certain point has been justified. This seems extremely logical to persons who are not students of tuberculosis and do not appreciate the fact that the tuberculin test is the sheet-anchor of any tuberculosis control program. We lament the fact that we do not have a sensitive biological test for cancer, that is, one that would detect the presence of this disease before the lesions are large enough to be located by our present methods of examining the human body. It is repeatedly said that if we only had such a test we would immediately seek out the reactors and make careful examinations while it can still be cured. We have just such a test for tuberculosis and there are those who do not use it." Abstracted from paper of Abraham E. Jaffin, M.D., in Public Health News, N. J. Dept. Health, Feb. 1952, p. 53.

* * * * *

REPORT OF THE COMMITTEE ON SCHOOL NURSING POLICIES AND PRACTICES

Minimum Basic Preparation for School Nursing

The school nurse participates with others in the school in planning and developing a school health program which will take into consideration the personal and environmental needs of the child and will promote the health of the school personnel. She participates in interpreting the principles and plans which underlie healthful school living and in working with school personnel to establish and maintain safe and healthful school environment including organization of the school day.

The nurse works with appropriate administrative officials in developing, conducting and evaluating school health programs and interpreting their purposes and scope.

The nurse serves as a health advisor in curriculum planning, interpreting to the school staff home backgrounds and community conditions which affect the health of children; helping teachers to relate health instruction and guidance to specific needs; assisting in the selection of authentic health education teaching materials. She helps interpret the school health program to the home and community and the health needs of the home and community to the school, aiding them to coordinate their efforts effectively. Therefore it is recommended that the full time nurse have before permanent appointment the following qualifications:

I. Personal.
   1. Pleasant, adaptable personality.
   2. Integrity, sensitivity, and ability to work with others.
   3. Interest in and understanding of children.
   4. Interest in increasing her preparation for increased efficiency in the program she is expected to carry out.

II. Professional preparation.
   1. Graduation from a school of nursing accredited by the State Board of Nurse Examiners or other legally authorized state body at the time when the nurse completed her education. This preparation should include or be supplemented by sufficient experience in pediatric nursing to insure the nurse's insight into health problems of children.
   2. Licensure to practice professional nursing by a legally authorized state body usually the Board of Nurses Examiners. This includes current registration.
   3. Bachelors degree which includes 20 hours of course instruction in the fields of education, sociology, public health or in combination.

III. If there is an insufficient number of nurses available who

are enrolled in or are eligible for enrollment in an approved collegiate program offering public health or education may be employed with an arrangement that they will complete a degree program in a definite time.

The above work should include or be supplemented by:

1. Course instruction and field work in school nursing.
2. Instruction in organization and philosophy of public schools.
3. Human growth and development with special attention to school age children.
4. Health education.
5. Techniques of counseling.
6. Nutrition.
7. Epidemology.
8. Social case work.
9. Psychology. Emily Brown Eunice Lamona
10. Mental hygiene. Eva Johnson Helen Schriener

Gertrude E. Cromwell, *Chairman*

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Membership, American School Health Association,—"Intensified efforts are being made to enlarge the A.S.H.A. membership and the effectiveness of its work. In so doing it may be you will receive a letter of invitation to join the Association of which you are already a member, since hundreds of such letters are being mailed by the Association Membership Chairman to lists of prospective members. It is frequently impossible to check such lists. Don't become irritated if you should get such and are already a member." * * * * *

Personnel,—School Health. Allan R. Cunningham, M.D., has been temporarily appointed assistant director of hospitals, survey, and planning for the Massachusetts Department of Public Health. Dr. Cunningham will work with Dr. A. Daniel Rubenstein, Director of the State Division of Hospitals in the Division's program to improve hospital facilities throughout the State.

Well-known to readers of *News Letter,* Dr. Cunningham joined the State health department in March, 1948, as Chief of the Section of Health Information and school health activities. Since September, 1950, he has served full-time as Chief of the School Health Section, Division of Maternal and Child Health.

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Dental Health Education. The American Dental Association has recently issued a list of "Dental Health Education Material, 1952." Address, American Dental Association, 222 East Superior St., Chicago II, Ill.

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EDITORIAL

This issue of the Journal carries an abbreviated article by Abraham E. Jeffin, M.D., a leader in the field of tuberculosis control arguing against the discarding of the tuberculin test in tuberculosis case seeking.

This is a note that greatly needs sounding. The years long practice among the leaders in this field, of tuberculin testing followed by the X-raying of the positives, has, supplemented by forceful campaigns of education, resulted in a phenomenal decrease in death rate from tuberculosis in the United States. Seemingly, this combination has been the most successful of any effort in the world.

A few years ago, the advocates of the use of the X-ray for the diagnosis of tuberculosis, in their eagerness to push the use of X-rays, began to drop the preliminary step of the tuberculin skin test. Numerous articles, written by expert leaders in the field of tuberculosis, have urged that the skin test be retained as an essential part of the program for early finding of cases of tuberculosis.

In furtherance of this more scientific and more thorough effort at case finding, numerous articles and abstracts have appeared in the Journal of School Health. The January 1951 issue of the Journal was devoted almost wholly to advocacy of this program. It does

not seem necessary to repeat here those arguments.

The X-ray campaign lends itself readily to publicity for which many seek. However, since the tuberculin skin test shows that only a small percentage of our people—and this applies particularly to the young—have tuberculosis, to X-ray the chests of every person seems wasteful as well as inaccurate.

We are an impatient people, easily led into short cuts. This particular short cut seems to be leading us—not to the scientific upland of success, but into a morass of doubt and ineffectiveness.

A recent questionnaire sent to the Advisory Committee on Chest Diseases of the Medical Society of New Jersey disclosed *unanimous* agreement that tuberculin screening should not be abondoned.

In view of the great preponderance of opinion favoring the continuance of tuberculin screening, it does not seem amiss to urge those persons and groups depending for early diagnosis on the use of the X-ray alone, to reassess their program and to get in line with what seems the more scientific and more thorough program.—*C.H.K.*

SCHOOL HEALTH PROBLEMS

THIRD EDITION

By Laurence B. Chenoweth, M.D.
and Theodore K. Selkirk, M.D.

- This is a scientific and up-to-to-date discussion of health problems in schools for the use of college students of school hygiene, school physicians, and individual teachers. It surveys not only current medical knowledge, but also the best educational practice in dealing with the problems of physical examination and inspection, accident problems in schools, etc. Included is an "Outline on School Health Administration," by Richard Arthur Bolt, M.D. The book is richly illustrated with pictures, charts, and tables, and contains references, bibliographies, a helpful glossary, and a full index. *419 pages, $3.35.*

APPLETON - CENTURY - CROFTS

35 W. 32nd Street, New York 1, N. Y.

ABSTRACTS AND NOTES

Scholarships for Scholarship,—"No college scholarships should be granted except on the basis of scholastic and personal achievements for both athletes and non-athletes," says a committee report to the North Central Association. "The granting of athletic scholarships has been the basis for many of the current abuses and is indefensible. When college athletes go before state compensation boards, petition for and are granted disability pay when injured, the ridiculous end-results of such a practice are apparent.

"To forestall the abuses of proselyting, contract by colleges with prospective students should be made only by their Admissions Officer, through the office of the high school principal..

"It is quite disturbing to see high school athletes, when they become seniors, go 'shopping' to sell their athletic ability to the highest bidding college. Most colleges, directly or indirectly, are in the 'bidding' market. All too often the transaction is encouraged, aided, and abetted by the high school coach. As a result of this, too many athletes measure the value of their participation in terms of dollars. It is difficult to believe that there is not some connection between this practice and the acceptance of bribes by college athletes. It must be difficult indeed for a college boy to see the moral wrong in accepting bribes to control the score in a basketball game when in all probability he was 'bribed' in the first place to attend and play for the school which he represents." Phi Delta Kappan, March 1952, p. 353.

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Health of Teachers,—Health in all its aspects is now considered to be fundamental to success in teaching. Too frequently, however, school health programs are concerned only with the health of the children, omitting provisions for maintaining and promoting the teachers' health.

The most comprehensive study of teachers' health so far was made some years ago by the Department of Classroom Teachers of the National Education Association. The statistical evidence collected suggested that the health of teachers as a group compares favorably with that of other groups of workers and of the general population.

When we consider health in terms of the total personality of an individual, it means more than the mere absence of physical and mental illnes. In its broadest sense, health includes other virtues such as pleasing personality, sound ethical character, intellectual honesty, emotional stability, and the ability to work well with others. These virtues are considered to be essential for genuinely

successful teaching. Teachers have demonstrated that their own health practices and attitudes toward health, expressed in their looks and manner, are more important in teaching health than a mere recitation of facts in the classroom.

For the children's welfare, as well as their own, teachers should be free from communicable diseases. Usually most adults are immune to the minor communicable diseases of childhood because they have had them. It is highly recommended that teachers should be immunized against diphtheria and vaccinated against smallpox every five years.

One of the disorders which ranks highest in causing illness among teachers is respiratory infections, particularly colds. Teachers, like many other groups, too frequently do not consider a cold a legitimate cause of absence from work. If there is no sick leave with pay given by the school board, teachers are prone to work when ill, endangering their own health, and in many cases the health of their pupils.

Among communicable diseases causing death among the school age group, tuberculosis is one of the leaders. To rule out the teachers as a possible source of infection, it is recommended that they submit evidence of freedom from tuberculosis before certification and employment and periodically thereafter.

Two other disorders which commonly cause illness among teachers are nervous indigestion and nervousness. The term "nervousness" covers a multitude of unpleasant symptoms, ranging from phychosomatic disturbances, such as nervous indigestion and nervous headache, to serious personality disorders of various kinds. Some of them are caused by conditions that teachers themselves can remedy by improved personal health practices. Others arise from circumstances largely beyond the individual teacher's control such as community restrictions in the way they spend their leisure time as well as in the number of hours of leisure. Fortunately, this situation is changing because of the growing emphasis on the vital need in a democratic society for cooperation between school and community.

It is recommended that no teacher who is not in good physical condition and free from communicable disease be permitted to work in direct contact with the boys and girls of the state. Further, no teacher should be granted a certificate for the first time who does not submit a health certificate from a physician licensed to practice medicine in all of its branches in the state of Illinois.

The Illinois law provides that no teacher shall be certified to

teach in the schools of the state who is not in good health. The only sure way to find out whether or not the teacher meets this requirement is by having a health examination including a laboratory diagnosis..

Too often, the effectiveness of the pre-employment examination is lost, because subsequent re-examinations at regular intervals have not, in all cases, been required by school boards. It is recommended that teachers present annually to the school board a certificate of physical fitness signed by a physician licensed in Illinois to practice medicine in all of its branches.

The health of teachers is directly related to the amount of security provided for them and the compensation received. School systems throughout the state are making an honest effort to adopt a salary schedule suitable to their size and income in an attempt to guarantee an adequate standard of living for teachers.

The Illinois tenure law has contributed to the security of the teacher as has the State retirement plan which provides opportunity for retirement because of disability, ill health or advanced age. Some teachers have taken advantage of group health and accident insurance and a hospitalization plan which also have contributed to their feeling of security.

The rise in the birth rate which began in 1940 caught many schools wholly unprepared to meet the tidal wave of new pupils who began entering school five or six years later. This tidal wave is now approaching the secondary schools. There have not been enough teachers entering the profession to balance the increase in the number of children entering school. School buildings are antiquated and classes are overcrowded in many communities; aids to teaching are often woefully inadequate. However, current and expected increases in the school population have given great impetus to long-overdue school-building programs in many Illinois localities. In the construction of new schools or in the remodeling of existing ones, environment should be considered, not only in terms of pupil health, but also for the teachers'health. Illinois Health Messenger, February 1, 1952, p. 10.

Reference: Health Bulletin for Teachers, December, 1951, Metropolitan Life Insurance Company.

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Our Rural School Sanitation . . . A Problem to Be Faced — *Harold L. Lautz.* It should be alarming to the people of Wisconsin to learn that nearly 70 per cent of our 4,000 or more one-room schools have actually or potentially unsafe water supplies. A num-

ber of them have no water supplies at all. Along with this health hazard of impure water, no comfort can be had from the information that slightly over 70 per cent of these schools have inadequate and insanitary toilet facilities.

Public health engineers in the nine districts of the State Board of Health have been familiar with the general sanitation problems in rural schools for the past 15 years. A questionnaire concerning the present status of rural school sanitation was recently sent to all district public health engineers. Information was sought on the condition of school water supplies, toilet facilities, sewage disposal, hand washing, and miscellaneous other sanitary facilities.

In the northeast section of the state, in the area surrounding Green Bay, the questionnaires showed that 90 per cent of the rural schools had hazardous water supplies, or none at all, and that 95 per cent of the toilet facilities were unsatisfactory. In the southwest district, 85 per cent of the school water supplies were defective and 80 per cent of the toilets were insanitary. Other areas of the state also had little reason to be proud, according to the questionnaires.

Pollution of Wells,—Supplementary information revealed that many school wells are so poorly constructed that they are continuously or intermittently polluted by sewage or surface water. A very large number of schools have no well on the premises. Water therefore must be carried in cans, pails, or other containers from wells of questionable quality at nearby farms, cheese factories, churches, or taverns. The added hazard is the contamination that could be introduced through soiled containers and careless handling.

Some school water supplies are derived from open springs having insects and debris floating on the water surface. Rodent hairs are frequently pumped from some school wells. Surface water containing the excreta of birds and small animals is flowing directly into some improperly protected school wells. Many wells which have been tested by the State Laboratory of Hygiene and found to be contaminated are still being used.

While water-flush toilets are certainly the goal of any school, other types of toilets surely can be sanitary. Reports indicate that the large majority of outdoor privies at these schools are not fly-tight, rodent-proof, properly vented and substantially constructed.

School Board Responsibility,—Responsibility for providing and maintaining adequate and safe sanitary facilities at the schools rests squarely on the shoulders of the respective school boards.

While some school boards have taken giant strides in providing excellent modern sanitary facilities for their schools, all too frequently school boards are prone to discount the seriousness of a polluted well or filthy toilet. They trust to luck that typhoid fever, dysentery, or some other intestinal diseases will by-pass their particular school.

The existing problem is all too clear: Poor sanitation exists, particularly with respect to water supplies and toilet facilities, in an astoundingly large percentage of our rural schools; there are discouragingly few qualified personnel available to educate and advise school boards on sanitation matters; and there is hesitation on the part of school boards to provide the sanitary improvements when advice is given.

Why has not the State Board of Health been able to devote more time to this problem? No state funds have ever been provided for a rural school sanitation program. The State Board of Health, through its nine district public health engineers, is required to carry out a sanitation program covering all problems. Thus it is able to give direct service to only a very small percentage of the thousands of schools in the state.

The Wisconsin legislature has recognized the existence of the state-wide school sanitation problem and has referred the entire problem to the Legislative Council for special study. It is believed that out of this study will emerge a workable solution to this problem which has for so long vexed all who have tried to combat it. Bimonthly Bulletin of the Wisconsin State Board of Health, Jan.-Feb., 1952. p. 22.

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Fluoride By Mouth During Pregnancy,—To the Editor: Will fluoride given to the mother by mouth during pregnancy cause the baby to have better teeth in life? *Needham B. Bateman, M. D., Atlanta, Ga.*

Answer.—There is no evidence that fluoride taken by the mother during pregnancy will cause a baby to have better permanent teeth. Since the tooth buds of the permanent teeth are not even formed at the time of birth, it is difficult to see how fluoride can affect the baby's future teeth in utero. Journ. A.M.A., March 1, 1952.

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Fluoridation of Water Supply,—The addition of fluoride to community water supplies as a public-health measure to reduce tooth decay in children has received much support from dentists and public-health personnel.[1] The American Dental Association decided recently that the addition of fluoride to drinking water has

been of sufficient value in the partial prevention of dental caries in children to warrant further large-scale investigation. Before stimulating such a program the Dental Association requested an opinion from the American Medical Association concerning the safety of this procedure. The Council on Pharmacy and Chemistry of the American Medical Association was asked to investigate the evidence on this subject and submit a report that could be transmitted to the Dental Association. It was found that the fluoridation of water supplies has been undertaken in over 120 communities in which the amount of fluoride naturally present was deficient. In a few other communities the drinking water was found to contain as much as 8 to 14 parts per million. In such communities it was also found that a mottling of the enamel of teeth in children could occur. No evidence of toxicity other than the effect on the enamel has been reported in these communities. Surprisingly, mottled teeth were more free from decay than were normal teeth.

In pursuing the matter further the Council on Pharmacy and Chemistry found no evidence that a concentration of one part per million in a community water supply would produce anything more than a slight mottling of the enamel. Thousands of examinations have been made of children who have drunk such water for relatively long periods; it was found that in only a small percentage was any mottling observable. This was minimal and was detected only by careful dental observation. Neither appearance nor strength of teeth was apparently affected. No other evidence of toxicity was obtainable.

It was reported[2] that the use of drinking water containing up to one part per million of fluoride was safe and that further investigation was warranted. It was pointed out, however, that where the regular drinking water supply contains, naturally or by supplementation, as much as one part per million of fluoride an additional fluoride intake should be avoided, such as might be obtained in lozenges, dentifrices, bone meal and chewing gum.

In addition, a special committee of the National Research Council has already endorsed the fluoridation of public water supplies to reduce tooth decay, and stated that the addition of fluorides to drinking water, properly controlled, appears to be both safe and effective. The limits set by this committee are 1.0 to 1.5 parts per million in the Northern United States and 0.7 parts per million in the southern part of the country.

Fluoridation of water is, of course, only one of the factors involved in lessening dental caries, and the addition of fluoride

to a community water supply in the proper amount cannot be expected to be the whole answer to the problem of dental decay. Education of the public, especially of children, will need to be continued in regard to the use of carbohydrates, general nutrition, care of teeth, regular inspection and so forth, as other important factors in preventing caries in teeth. In rural areas with wells and smaller water supplies these preventive methods will need to be emphasized.

There will, of course, be some objection from misinformed persons who will contend that the addition of minute amounts of fluoride to water is dangerous, just as many objections were made to the chlorination of water some years ago. However, there is no good evidence to support such ideas. There may also be objection to the program from certain groups, on the basis of infringement on individual liberty by providing for the forced ingestion of water containing a medicament.

It is obvious that any fluoridation of drink-water supplies would be carried out under adequate dental and engineering supervision, with constant chemical control by state board of health authorities. Since the evidence indicates no toxic effect from the proposed concentration of fluoride in drinking water and in view of the fact that the incidence of dental caries has definitely been lessened, it seems that the increasing use of fluorides in water supplies is fully justified. New England Journ. of Med., Feb. 28, 1952, p. 351.

REFERENCES

1. Hilleboe, H. W., and Ast, D. B. Public health aspects of water fluoridation. Am. J. Pub. Health 41:1370-1374, 1951.

2. Council on Pharmacy and Chemistry and Council on Foods and Nutrition. Fluoridation of water supplies. J. A.M.A. 147: 1359, 1951.

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Acne Vulgaris,—To the Editor: What is the primary cause of acne vulgaris? Is there a difference in racial susceptibility? Is there a correlation with occupation, e.g., farm workers as compared with industrial workers? Are geographical and climatic factors important? Jean Thompson Munzer, M.D., New York.

Answer,—There is considerable evidence to indicate that estrogen-androgen imbalance is a major, if not the primary, cause of acne vulgaris. Foods rich in iodine or fat, and hot and spicy foods play a contributory role, in that they irritate or overactivate the sebaceous apparatus. In some persons, racial susceptibility plays a part; inherently large and overactive sebaceous glands are prone to develop acne. The application of grease or oils to an already oily skin may produce acne by mechanical plugging of

pores. Thus certain machine workers and garage workers are more likely to have acne than are farmers. Climatic conditions also play some role, for it has always been noted that a sunny, dry climate is better for the patient with acne than is humid weather which activates the sabaceous apparatus. These are only a few of the many factors which influence acne, a complex and challenging condition. Journal A.M.A. Jan. 5, 1952. p. 88.

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Court Decision on Undulant Fever,—The Washington State Supreme Court has handed down a decision awarding damages for undulant fever contracted as a result of handling cattle infected with Bang's disease. The case involved a farmer who bought a dairy herd represented as Bang's-free, although at the time of sale it was under a U.S. Department of Agriculture quarantine. After a year, the disease had spread through the herd and the farmer became ill with undulant fever. The trial court's award of nearly $10,000—$5,000 damages to the farmer for having contracted undulant fever, $3,158 for loss of milk production, and $1,418 for the difference between what the farmer paid for the herd and what he received when the animals were sold for slaughter—was upheld by the higher court. Thus the public health dangers of brucellosis have become established by legal precedent. American Journal of Public Health, March, 1952, p. 292.

REVIEWS

Community Health Education in Action. *Raymond S. Patterson, Ph.D.*, and *Beryl J. Roberts, Ed.M., M.P.H.* The C. V. Mosby Co., St. Louis, 1951. 346 pp. Price $4.50.

This is a valuable text loaded with worthwhile information interestingly stated. The authors have long experience in preparing health education material for public use.

Its chapters deal with health education and the health educator, with the bases for organizing the community, with the laws of learning and with various ways of health education—word of mouth, writing, direct mail, annual report, health booklets; they discuss type, illustrations, exhibits, and the use of the daily press, the radio, picture projection, and, near the last, administrative matters and appraisal of methods. The text is ended with three appendixes,—I. Health Education in County Health Departments, II. Public Health Education in a State Department of Health, III. A Voluntary Agency's Health Education Effort.

This text should be in the library of every person engaged in a community health education program, and of those training teachers and workers in this field.—*Chas. H. Keene.*

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Health Instruction Year Book, *Oliver E. Byrd, M.D.*, Stanford University Press, Stanford, Calif., 1951. 236 pp. price $3.50. 9th ed.

The material in this edition is new, and includes condensations of articles published between July 1, 1950, and June 30, 1951. It is divided into twenty-one chapters ranging in title from "Health as a Social Accomplishment" through "Habit Forming Substances" to "Trends and Possibilities."—*Chas. H. Keene.*

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"Recreation Through Music." *Charles Leonhard.* A. S. Barnes, New York, 1952, pp. 160. Price $3.00.

Music and recreation represent a universal need of man. The importance of music as a part of community living is being increasingly recognized by the recreation leaders and the public. In order to utilize to the fullest the unique contributions and the infinite potentialities of music as recreation, the author has written a most welcome book, for musical layman, students and teachers; individ-

uals who wish to participate more actively in community singing, dancing, festival, band, orchestra, music clubs and professional recreation leaders.

Here are practical suggestions and simple directions for the conduct of the recreation music program and with an obvious understanding of the effective appeal of the Recreation Movement and the link between the trained leadership, the movement and the music.

To indicate the range of the text, the following chapters are devoted to:

Recreation and Music, Recreation Through Listening, The Recreation Leader and the Listening Program, Recreation Through Singing, The Recreation Leader and the Singing Program, Recreation Through Playing, The Recreation Leader and the Playing Program.—*Fritz Febel.*

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Health Counseling. *Milton Schwebel, Ph.D.* and *Ella Freas Harris, M.D.*, Chartwell House, Inc., New York, 1951. 238 pp.

Designed to add to the professional equipment, the various chapters deal with the objectives, philosophy and qualities needed by the Counselor, and the dynamics and techniques of health counseling.

Other chapters deal with the case work approach, the physician, referral and sources, ethics and evaluation.

This is a distinctly valuable text in a rapidly expending field.—*C. H. Keene.*

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Your Health and Safety. *Jessie Williams Clemensen* and *William Ralph La Porte,* Harcourt Brace & Company, 3rd Edition, 1952, 532 pp. Price $3.32.

A text at the high school level, revised to bring health information up to date. At the end of chapters appear lists of activities and references. The safety section carries much first aid instruction.—*C. H. Keene.*

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MEETINGS

The American School Health Association and American Public Health Association at Cleveland, Ohio, October 19th to 24th, 1952.

The New York State Association of School Physicians at Lake Placid, New York, June 3rd, 1952, in association with the Annual Conference of School Health Nurses.